First Transit

NETSPAP STANDING ORDER REQUEST

1229 N. Northbranch Suite 219
Chicago, Illinois 60622
(877) 725-0569 Voice (312) 327-3855 Fax

ALL BLANKS MUST BE ACCURATELY COMPLETED. FORMS SENT TO FIRST TRANSIT WITH BLANK SPACES OR INSUFFICIENT OR INACCURATE INFORMATION CANNOT BE PROCESSED

☐ New ☐ Renewal

☐ **APPROVED**
☐ Denied
☐ Denial Reason
☐ Returned Incomplete
Reference #

Requesting Organization Information

YOUR FAX NUMBER: _____ **Date You Initiated This Request:** _____ **Your Phone Number:** ( ) _____

Your Organization Name: _____

Your Name - Must match signature below: _____ Your Relationship to Participant: _____

Physician Name: _____ Phone: _____

Recipient Information

Recipient Name: _____ (Last) _____ (First) RIN: _____

Trip Information

Appointment Days:
Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐

☐ Behavioral Health Services _____ Beginning Date:(This request period) _____ UP TO AND INCLUDING 2 MONTHS

☐ Dialysis ☐ Physical Therapy ☐ Chemotherapy ☐ Radiation Therapy

_____ Beginning Date:(This request period) _____ UP TO AND INCLUDING 6 MONTHS

Pick Up Location Name: _____ Phone: _____

Pick Up Location Address: _____

Pick UpTime: _____ Appointment Time: _____ Return Time: _____

Pick Up City: _____ County: _____ State: _____ Zip Code: _____

Drop Off Location Name: _____ Drop Off Location Address: _____

Drop Off City: _____ County: _____ State: _____ Zip Code: _____ Phone: _____

Describe the reason the recipient can not use bus or train transportation: _____

Name of Transportation Provider Requested: _____

LEVEL OF SERVICE REQUESTED: (*MUST BE THE LEAST EXPENSIVE APPROPRIATE TRANSPORTATION REQUIRED TO ACCOMMODATE THE PATIENT'S CURRENT MEDICAL CONDITION.*)

☐ BUS/TRAIN ☐ PRIVATE AUTO ☐ TAXI	☐ SERVICE CAR ☐ NON-EMPLOYEE ATTENDANT	☐ ALS AMBULANCE ☐ BLS AMBULANCE ☐ OXYGEN/SUPPLIES	☐ MEDICAR WHEELCHAIR ☐ MEDICAR STRETCHER ☐ PROVIDER EMPLOYEE ATTENDANT ☐ NON-EMPLOYEE ATTENDANT

Comments: Please specify primary and secondary diagnosis as well as any other pertinent information regarding the patient's physical status.

I understand if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify, under penalty of perjury, that I have obtained the information on this form from the recipient and the information provided is accurate, to the best of my knowledge, and that I will notify First Transit of any changes in the information set forth above within 10 days of my becoming aware of such changes.

_____ _____

DCFS Medical Liaison/Medical Professional's Signature and Title (must match requesting person above.) Title
(Please circle applicable one)